Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
EDWARD F WOLSKI MD
C/O WOL+MED
2436 I-35 E SOUTH STE #336
DENTON TX 76205

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-06-1617-01

MFDR Date Received
NOVEMBER 1, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier initially denied most of these claims using PEC 'C'. However, we are NOT on the First Health/CCN WC PPO discount plan; therefore, no discount should be taken. I have enclosed documentation as proof of this fact. This same documentation was submitted with the request for reconsideration. Numerous correspondences have been sent to the carrier to correct this error. The carrier has once again failed to correct this error on this account. The carrier failed to respond to our initial billing for DOS 12/08/04, CPT 97110, DOS 12/3-/04, CPT 99213 and 99080-73, and DOS 1/20/05, CPT 07110 and 97530. Documentation is enclosed showing proof of receipt of initial billing. The carrier initially denied DOS 12/27/04, CPT 97799.AQ using PEC 'F'. However, I have enclosed documentation as proof of other carrier that pay our usual and customary for this charge. The carrier responded to our request to reconsider DOS 12/02/04 and 12/08/04 using PEC 'O'. The carrier failed to respond to the rest of our request for reconsideration. For these reasons, we feel the carrier has violated Rule 133.304 (c)…"

Amount in Dispute: $1,049.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as listed on the Table of Disputed Services: "Carrier w/ pay diff PPO cut. Unnecessary med tx. Docu does not support one-on-one therapy. w/pay diff PPO cut. DWC-73 form prev submitted 12/2/08 – permitted every 2 weeks. Unecessary [sic] treatment. Carrier agrees to pay. Limited to every 2 weeks. Never received billing. Please dismiss."

Response Submitted by: New Hampshire Insurance Co., 300 S. State. St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2004 December 8, 2004 December 10, 2004 December 13, 2004 December 17, 2004 December 31, 2004	CPT Codes 97110-59, 97799-22, 97530, 97113, HCPCS Code A4595 Denial Reason U-50, W9	$572.94	$0.00

December 8, 2004 December 10, 2004 December 13, 2004 December 17, 2004 December 22, 2004 December 27, 2004 January 10, 2004 January 12, 2005 January 20, 2005 January 21, 2005 January 24, 2005 January 28, 2005	CPT Codes 99080-73 (2 DOS), 97124 (3 Units), 97012 (4 Units), 97110-59 (4 Units), 97530-59 (4 Units), 99213 (2 DOS), 97113-59 (4 Units), 97537-59 (1 Unit) , 98940 (6 DOS) and HCPCS Code A9900 (3 DOS) Denial Codes 45, C, O	$130.02	$129.02
December 27, 2004	CPT Code 97799-22 Denial Code F	$48.00	$0.00
December 30, 2004 January 20, 2005 January 28, 2005	CPT Codes 99213 (1 DOS), 99080-73 (1 DOS), 97110-59 (2 Units) and 97530-59 (4 Units) No EOBs submitted by either party	$284.14	269.14
January 21, 2005	HCPCS Code A9900 Denial Code 45, W3	$1.00	$0.00
December 2, 2004	CPT Code 99070 – Polar Pac Denial Code C, 97	$13.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.308 sets out the procedure for resolving retrospective medical necessity issues.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on November 1, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 8, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The requestor submitted an updated table via e-mail on September 11, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - C – The charges have been priced in accordance to a contract owned or accessed by a First Health Company.
   - 97 – Payment is included in the allowance for another service/procedure. Unbundling – included in another billed procedure.
   - O – Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to PPO contract.
   - F – The procedure code submitted is not the proper code for this service. Please resubmit with the proper code.
   - U – 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer, unnecessary treatment (without peer review).

- 45 – Charges exceed your contract/legislated fee arrangement. The charges have been priced in accordance to a contract owned or access by a First Health Co.
- W3 – Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.
- UDOC – 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Submitted documentation does not support or meet the criteria for one-on-one therapy. Unnecessary medical treatment or services.
- RUR – W9 – Unnecessary med treatment based on peer review. Payment withheld as peer review indicates documentation does not support the treatment to be medically reasonable and/or necessary.

Issues

1. Did the requestor submit dates of service that were denied for medical necessity?
2. Did the requestor support they did not have a workers' compensation contract with First Health?
3. Did the requestor support their billing of CPT Code 97799-22 as fair and reasonable?
4. Were EOBs submitted by either party for these codes?
5. Did the requestor receive payment for this code?
6. Did the requestor bill a bundled code?
7. Is the requestor entitled to reimbursement?

Findings

1. CPT Codes 97110-59, 97799-22, 97530, 97113, HCPCS Code A4595, for dates of service December 6, 20004, December 10, 2004, December 8, 2004, December 13, 2004 and December 17, 2004 were denied by the carrier using denial code U – 50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer, unnecessary treatment (without peer review)." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The insurance carrier reduced or denied disputed services with reason code C – "The charges have been priced in accordance to a contract owned or accessed by a First Health Company" and 45 – "Charges exceed your contract/legislated fee arrangement. First Health sent a letter, dated January 25, 2005, to the requestor stating "We deeply regret to announce that this provider was loaded into the First Health system under the work comp project in error. During his tenure with First Health there should not be any workers' compensation discounts taken from his claims." Therefore, the above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
    - CPT Code 99080-73; dates of service December 8, 2004 and December 22, 2004 – In accordance with 28 Texas Administrative Code §129.5 the doctor shall file the Work Status Report (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's schedule appointments with the employee. Review of the Work Status Reports submitted by the requestor show that the December 2, 2004 Work Status Report the treating doctor will allow the employee to return to work, with restrictions, as of December 6, 2004; on December 8, 2004 the Work Status Report indicates the treating doctor took the injured worker off light duty as injured worker was in severe pain and unable to tolerate light duty. On December 20, 2004 the Work Status Report indicates the treating doctor allowed the employee to return to work as of December 21, 2004 with restrictions; on December 22, 2004 the treating doctor took the injured worker off light duty as the injured worker was unable to tolerate light duty. The Work Status Reports support reimbursement; therefore, reimbursement is recommended.
    - CPT Code 97124; dates of service January 10, 2005, January 21, 2005 and January 28, 2005 –

Review of the physicians record supports reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(1). Therefore additional reimbursement is due.

- CPT Code 97012; dates of service January 10, 2005,January 12, 2005,January 20, 2005 and January 24, 2005 - Review of the physicians record supports additional reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(1).
- CPT Code 97110-59; dates of service January 10, 2005 and January 12, 2005 - Review of the physicians record supports additional reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(1). .
- CPT Code 97530-59; dates of service January 10, 2005 and January 12, 2005 - Review of the physicians record supports additional reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(1).
- CPT Code 99213; dates of service December 27, 2004 and January 12, 2005 - Review of the chiropractor progress record supports additional reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(1).
- CPT Code 99113-59; dates of service January 12, 2005 and January 24, 2005 – Review of the physicians record supports additional reimbursement in accordance with 28 Texas Administrative Code §134.202(c)(1).
- CPT Code 97537 for date of service January 28, 2005 – Review of the physicians record supports additional reimbursement in accordance with Texas Administrative Code §134.202(c)(1).
- CPT Code 98940; dates of service December 10, 2004, December 13, 2004, December 17, 2004, January 10, 2005, January 21, 2005 and January 28, 2005 – Review of the chiropractor records supports additional reimbursement in accordance with Texas Administrative Code §134.202(c)(1).
- HCPCS Code A9900; dates of service January 10, 2005 – Review of chiropractor progress notes for this date of service does not support that the application of Biofreeze was used. Therefore, additional reimbursement is not recommended.
- HCPCS Code A9900; dates of service January 21, 2005 and January 28, 2005 - Review of the chiropractor progress notes supports additional reimbursement in accordance with Texas Administrative Code §134.202(c)(6).
- CPT Code 98940; dates of service December 10, 2004, December 13, 2004, December 17, 2004, January 10, 2005, January 21, 2005 and January 28, 2005. Review of the chiropractor progress notes supports additional reimbursement in accordance with Texas Administrative Code §134.202(c)(1)

3. The requestor requested reimbursement in the amount of $48.00 for CPT Code 97799-22, listed as aqua jet massage, on December 27, 2004.The -22 modifier is a surgery modifier used for unusual procedural services; the requestor has not submitted any documentation to support the use of modifier -22; the requestor listed this code with modifier AQ on the table of disputed services. The AQ modifier is defined as: physician providing a service in a Health Professional Shortage Area (HPSA). The Texas Workers' Compensation system did not provide for HPSA or PSA until January 11, 2008; therefore, the requestor has attached an incorrect modifier. This code relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission." The requestor has submitted redacted EOBs to support the billed amount. In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
4. Neither party submitted EOBs for CPT Codes 99213 and 99080-73, date of service December 30, 2004; 97110-59 (2 Units) and 97530-59 (2 Units), date of service January 20, 2005; and 97530-59 (2 Units), date of service January 28, 2005. The carrier assets in their position summary that they never received billing for date of service December 30, 2004. The requestor submitted a USPS Track & Confirm supporting that bills were delivered at 5:51 am on January 19, 2005 in Lexington, KY 40512. The item was signed for by J Conkin. Review of the physician records and CCI edits supports reimbursement for CPT Codes 99213, 97110-59 and 97530-59. In accordance with 28 Texas Administrative Code §129.5(d)(2) the injured workers has not experienced a change in work status or a substantial change in activity restrictions. Therefore, reimbursement is not recommended for the Work Status Report.
5. The requestor billed $10.00 for CPT Code A9900 – Biofreeze on December 17, 2004. The respondent initially reduced the payment using payment exception code 45 – "Charges exceed your contracted/legislated fee

arrangement. The charges have been priced in accordance to a contract owned or access by a First Health Co." and paid $9.00. According to the Invoice EOR Summary received in the Division on January 18, 2006, the carrier re-audited this code and paid the remaining amount of $1.00. Therefore, additional reimbursement is not recommended.

6. The insurance carrier reduced or denied CPT Code 99070 with reason code 97 – "Payment is included in the allowance for another service/procedure. Unbundling – included in another billed procedure" and C – The charges have been priced in accordance to a contract owned or accessed by a First Health Company." Pursuant to 28 Texas Administrative Code §134.202(b)For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. CCI Edits show this code is considered a bundled. Payment for this service is always bundled into payment for other services not specified and no separate payment is made. Therefore, reimbursement is not recommended.
7. Review of the submitted documentation finds that partial additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $398.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $398.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 19, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.